NEW YORK STATE OF OPPORTUNITY. | Central New York Psychiatric Center

KATHY HOCHUL
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DANIELLE DILL, PSY.D.
Executive Director

CERTIFICATION

I, Stephanie DePerno, RHIA, I am the Director of the Health Information Management Department at Central New York Psychiatric Center, Marcy, New York. I hereby certify that the enclosed are true and correct copies from the Central New York Psychiatric, King, Joseph, C#: 243229, date of birth 06/03/1968 follows:

CENTRAL NEW YORK PSYCHIATRIC CENTER INPATIENT RECORD

08/15/2013-11/16/2018

Total Pages: 374

I also certify that these records were made in the ordinary course of business of this hospital and that it was in the regular course of the business of this hospital to make such records at the time at which they were prepared.

Stephanie DePerno, RHIA, Director of Health Information Management Department

OMH CNYPC (7/14)

PSYCHIATRIC PROGRESS NOTE

Patient/Resident's Name: (Last, First, M.I.) King, Joseph CR: 249229
Date of Birth: [redacted] DIN#: 13A3662
Unit/ Ward: Midstake cP
Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Completed when indicated by the prescriber. Enter date and time of service. Document program (i.e. RCTP, ICP etc.) if in outpatient service.

Date & Time: 5/14/18 10:45AM
Program: GP JTC

MED15 DIAGNOSES: (primary diagnosis should be listed first with a "P" notation)
Mental Health: Adjustment Disorder with mixed Anxiety & Depressed Mood
Physical Health: No acute issues

CHIEF COMPLAINT AND CURRENT ISSUES: (Include complaints, preoccupations, worries, issues, etc.) pt is a 49 y/o man on his 1st MHS BID, CR 5/2018 & reported hx of past MH treatment for depression, self-harm & substance use. pt per his mother 1 week ago. Today he reports "needing something to calm me down." He reports feeling depressed, anxious, sleeping poorly. We discussed that some of his symptoms are appropriate to his recent loss. pt is adamant he was struggling prior to the loss of his mother & is requesting med change.

CHANGES IN MEDICAL STATUS: (include lab work, etc.) No reported changes

MENTAL STATUS EXAMINATION AND CHANGES: (Include stable/not stable, response or lack of response to treatment, improving (or not); decompensating)

Caucasian man, thin, dressed appropriately in prison attire, fair eye contact, polite, calm, cooperative, pleasant & cooperative. Speech - normal tone & rate, mood: "not good" affect: Anxious linear thought process, denies SI/HI denies AH/VH

ASSESSMENT OF SUICIDE RISK: Describe suicide risk warning signs/triggers (IS PATH WARM, Prison Based, or Individual) which are present or indicate none are present:
⊕ Anxiety, recent loss of mother
pt denies current SI, has support from sister & is goal directed for treatment.

Continued on page 2.

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PSYCHIATRIC PROGRESS NOTE (con't)

Patient/Resident's Name (Last, First, M.I.)	DIN#	CH#
King, Joseph	13A3662	24329

ASSESSMENT /CURRENT DIAGNOSTIC IMPRESSION/ PLAN: *(Include changes to diagnoses and/or treatment options. Indication for each psychiatric medication must be documented either here, below in the Medication Section, or in the Physician Orders)*:

will continue to track celexa & vistaril to address mood & anxiety. continue therapy.

LIST OF ALL CURRENT PSYCHIATRIC AND MEDICAL MEDICATIONS: *(Include all current medications from transferring unit/facility including medical meds at the first visit after transfer. For subsequent notes, list all psychiatric meds and any changes to medical meds made since admission to this unit). Include dose and frequency for each psychiatric medication listed.*

Psychiatric Medications:

1. celexa 40mg po PM -depression
2. vistaril 100mg po PM -anxiety
3.
4.

Medical Medications:

1. None
2.
3.
4.

MEDICATION EDUCATION PROVIDED *(check when provided)*: ☐

ADDITIONAL INFORMATION:

FOLLOW-UP *(Indicate next appointment)*: 4-6 weeks - prn

SIGNATURE/TITLE: K. Thomas MD / psych # DATE: 5/14/18
Karen Thomas

OMH-PHI

OMH-NED CNYPC (9/14)

PSYCHIATRIC PROGRESS NOTE

Patient/Resident's Name: (Last, First, M.I.) King, Joseph CH: 243729
Date of Birth: [redacted] DIN#: 13A3662
Unit/ Ward: Mid State
Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Completed when indicated by the prescriber. Enter date and time of service. Document program (i.e. RCTP, ICP etc.) if in outpatient service.

Date & Time	Program
6/25/18 9:35AM	GP VTC

MEDICAL DIAGNOSES: (primary diagnosis should be listed first with a "P" notation)
Mental Health: Adjustment Disorder with Mixed Anxiety + Depressed Mood
Physical Health: No acute issues

CHIEF COMPLAINT AND CURRENT ISSUES: (Include complaints, preoccupations, worries, issues, etc.) Pt reports feeling the same c the recent med changes. Pt received a drug ticket after the loss of his mother. He admits to using smoke a few times since last seen 5/14/18. Pt c/o feeling unmotivated tired + depressed. He rates depression 7/10 + states he's been feeling this way for months. Pt reports last being clean from smoke for 6 months in 2017.

CHANGES IN MEDICAL STATUS: (Include lab work, etc.) No reported changes

MENTAL STATUS EXAMINATION AND CHANGES: (Include stable/not stable, response or lack of response to treatment, improving (or not); decompensating)

Caucasian male dressed appropriately, fair eye contact, no psychomotor disturbance calm, cooperative Speech - normal tone + rate, Mood: "Not good" Affect: Constricted, Goal directed thought process, Denies SI/HI Denies AH/VH

ASSESSMENT OF SUICIDE RISK: Describe suicide risk warning signs/triggers (IS PATH WARM, Prison Based, or Individual) which are present or indicate none are present:
No warning signs present

Continued on page 2.

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PSYCHIATRIC PROGRESS NOTE (con't)

Page 2

Patient/Resident's Name (Last, First, M.I.)	DIN#	C#
King, Joseph	13A3662	243224

ASSESSMENT /CURRENT DIAGNOSTIC IMPRESSION/ PLAN: *(Include changes to diagnoses and/or treatment options. Indication for each psychiatric medication must be documented either here, below in the Medication Section, or in the Physician Orders)*:

Discussed current symptoms + suboxone use. will taper - D/C celexa + vistaril → pt doesn't find effective. Discussed initiating AM med trial c̄ prozac - pt declines at this time. continue therapy.

LIST OF ALL CURRENT PSYCHIATRIC AND MEDICAL MEDICATIONS: *(Include all current medications from transferring unit/facility including medical meds at the first visit after transfer. For subsequent notes, list all psychiatric meds and any changes to medical meds made since admission to this unit). Include dose and frequency for each psychiatric medication listed.*

Psychiatric Medications:

1. Celexa taper + D/C
2. Vistaril taper + D/C
3.
4.

Medical Medications:

1. None
2.
3.
4.

MEDICATION EDUCATION PROVIDED *(check when provided)*: ☐

ADDITIONAL INFORMATION:

FOLLOW-UP *(Indicate next appointment)*: 2 months + prn

SIGNATURE/TITLE: [signature] NP [illegible] DATE: 6/25/18
Karen Thomas

OMH-PHI

PSYCHIATRIC PROGRESS NOTE

Patient/Resident's Name: (Last, First, M.I.) King Joseph
Date of Birth: [redacted] DIN#: 13A3662 CH#: 243229
Unit/ Ward: Midstate CF
Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Completed when indicated by the prescriber. Enter date and time of service. Document program (i.e. RCTP, ICP etc.) if in outpatient service.

Date	Program
7/13/18 (10:20 AM)	GP JTC

MED15 DIAGNOSES: (primary diagnosis should be listed first with a "P" notation)
Mental Health: Adjustment Disorder with Mixed Anxiety & Depressed Mood
Physical Health: No acute issues

CHIEF COMPLAINT AND CURRENT ISSUES: (Include complaints, preoccupations, worries, issues, etc.) Pt reports feeling worse. He states he has a lot of anxiety & reports pacing during the day & "panic attacks." Panic attacks consist of feeling warm, numb & cause him to get up when trying to sleep. Pt reports feeling more depressed, but denies SI. He states he's been driving his wife crazy & asked her to call MH to explain he was not doing well. Sleep has been more difficult. Pt reports & difficulty concentrating & trouble to read or do puzzles. He continues to have support from his wife & CO. Pt requests to restart trazodone & reports decr. irritation & frequency.

CHANGES IN MEDICAL STATUS: (include lab work, etc.) No reported changes

MENTAL STATUS EXAMINATION AND CHANGES: (Include stable/not stable, response or lack of response to treatment, improving (or not); decompensating)

Caucasian male appropriately dressed, fair eye contact, calm, cooperative, abnormal movements, speech-normal tone & rate, mood: "depressed" affect: congruent, linear thought process, denies SI/HI, denies AH/VH

ASSESSMENT OF SUICIDE RISK: Describe suicide risk warning signs/triggers (IS PATH WARM, Prison Based, or Individual) which are present or indicate none are present:
No warning signs present

Continued on page 2.

PSYCHIATRIC PROGRESS NOTE (con't)

Patient/Resident's Name (Last, First, M.I.)	DIN#	CH
King, Joseph	13A3662	24322

ASSESSMENT /CURRENT DIAGNOSTIC IMPRESSION/ PLAN: *(Include changes to diagnoses and/or treatment options. Indication for each psychiatric medication must be documented either here, below in the Medication Section, or in the Physician Orders):*

will initiate med mgt - zoloft & trazodone to address anxiety & depression. Continue therapy.

LIST OF ALL CURRENT PSYCHIATRIC AND MEDICAL MEDICATIONS: *(Include all current medications from transferring unit/facility including medical meds at the first visit after transfer. For subsequent notes, list all psychiatric meds and any changes to medical meds made since admission to this unit). Include dose and frequency for each psychiatric medication listed.*

Psychiatric Medications:

1. zoloft 50mg po PM for depression & anxiety
2. trazodone 50mg po PM
3.
4.

Medical Medications:

1. None
2.
3.
4.

MEDICATION EDUCATION PROVIDED *(check when provided)*: ☑

ADDITIONAL INFORMATION:

FOLLOW-UP *(Indicate next appointment)*: 4-6 weeks + prn

SIGNATURE/TITLE: Karen Thomas DATE: 7/23/18

Karen Thomas

OMH-PHI

CNYPC (7/14)

PSYCHIATRIC PROGRESS NOTE

Patient/Resident's Name: (Last, First, M.I.) King, Joseph CII: 243229
Date of Birth: [redacted] DIN#: 13A3662
Unit/ Ward: Midstate CF
Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Completed when indicated by the prescriber. Enter date and time of service. Document program (i.e. RCTP, ICP etc.) if in outpatient service.

Date & Time	Program	
8/27/18 9:30AM	GP VTC	MED15 DIAGNOSES: (primary diagnosis should be listed first with a "P" notation) Mental Health: Adjustment Disorder with Mixed Anxiety + Depressed Mood Physical Health: No acute issues CHIEF COMPLAINT AND CURRENT ISSUES: (Include complaints, preoccupations, worries, issues, etc.) Pt seen for his follow-up. He explains he's not doing well + feels edgy. Pt admits to smoking K2 1-3X since last appointment. States it helps with his anxiety but wants + plans to stop. He reports feeling depressed, edgy + unmotivated. Pt denies SI but reports anhedonia + mostly laying in his bed during the day. Pt reports sleeping 3-4 hours at a time c Trazodone. ~~Sleep hygiene discussed.~~ Pt continues to have support from his wife + kids. CHANGES IN MEDICAL STATUS: (include lab work, etc.) No reported changes MENTAL STATUS EXAMINATION AND CHANGES: (Include stable/not stable, response or lack of response to treatment, improving (or not); decompensating) Caucasian man, appropriately dressed, intermittent eye contact, no psychomotor disturbance, speech normal tone + rate. Mood: "Not good" Affect: constricted. Linear thought process. Denies SI/HI. Denies AH/VH ASSESSMENT OF SUICIDE RISK: Describe suicide risk warning signs/triggers (IS PATH WARM, Prison Based, or Individual) which are present or indicate none are present: No warning signs present Continued on page 2.

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PSYCHIATRIC PROGRESS NOTE (con't)

Patient/Resident's Name (Last, First, M.I.)	DIN#	C#
King, Joseph	13A3662	243249

ASSESSMENT /CURRENT DIAGNOSTIC IMPRESSION/ PLAN: *(Include changes to diagnoses and/or treatment options. Indication for each psychiatric medication must be documented either here, below in the Medication Section, or in the Physician Orders)*:

Pt counseled on harms of substance use. He was encouraged to return to AA/NA. Pt will do anxiety packet from therapist to help learn relaxation techniques. Pt agreeable to plan & understands meds will be stopped this if drug use continues.

LIST OF ALL CURRENT PSYCHIATRIC AND MEDICAL MEDICATIONS: *(Include all current medications from transferring unit/facility including medical meds at the first visit after transfer. For subsequent notes, list all psychiatric meds and any changes to medical meds made since admission to this unit). Include dose and frequency for each psychiatric medication listed.*

Psychiatric Medications:

1. Zoloft 50mg PO PM
2. Trazodone 50mg PO PM — depression & anxiety
3.
4.

Medical Medications:

1. None
2.
3.
4.

MEDICATION EDUCATION PROVIDED *(check when provided)*: ☐

ADDITIONAL INFORMATION:

FOLLOW-UP *(Indicate next appointment)*: 2 months o/p

SIGNATURE/TITLE: [signature] MD PGY II — Karen Thomas MD DATE: 8/27/18

OMH-PHI

356 MED CNYPC (7/14)

PSYCHIATRIC PROGRESS NOTE

1st for Suicide attempt 8/2016

Patient/Resident's Name: *(Last, First, M.I.)* King, Joseph C#: 243249
Date of Birth [redacted] DIN#: 13A3062
Unit/ Ward: MSCF
Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Completed when indicated by the prescriber. Enter date and time of service. Document program (i.e. RCTP, ICP etc.) if in outpatient service.

Date & Time	Program
10/16/18 1300	MSCF

MED15 DIAGNOSES: (primary diagnosis should be listed first with a "P" notation)

Mental Health: P Adj Disorder c mixed anxiety + Depressed mood Etoh + Cannabis Use (severe) ± Borderline Personality Disorder (mod)

Physical Health: No acute issues

CHIEF COMPLAINT AND CURRENT ISSUES: *(Include complaints, preoccupations, worries, issues, etc.)* "I just need medicine to help me." Education provided to the pt. + discussion regarding primary treatment (DBT/SBU) building
- last documented Substance use 1st week of August.
- Earliest report: reports a board in January

CHANGES IN MEDICAL STATUS: *(Include lab work, etc.)*
NO acute changes/concerns

MENTAL STATUS EXAMINATION AND CHANGES: *(Include stable/not stable, response or lack of response to treatment, improving (or not); decompensating)*
Pt presented as polite appearing to have difficulty grasping his role in treatment + decision making. Eye contact. Dressed neatly + good grooming + hygiene. ± Appetite (throw poor sleep per pt. Seen normal rate + tone. Thought process/content circumstantial + tangential. Reports chronic anxiety + periods of low mood. No reported decreased S/S of psychosis. Denies SI/HI or AVH. Denies manic or psychotic symptoms.

ASSESSMENT OF SUICIDE RISK: *Describe suicide risk warning signs/triggers (IS PATH WARM, Prison Based, or Individual) which are present or indicate none are present:*
No acute risk of suicide. Only truthful of self harm

Continued on page 2.

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PSYCHIATRIC PROGRESS NOTE (con't)

Patient/Resident's Name (Last, First, M.I.)	DIN#	C#
King, Joseph	13A3606 2	243229

ASSESSMENT /CURRENT DIAGNOSTIC IMPRESSION/ PLAN: *(Include changes to diagnoses and/or treatment options. Indication for each psychiatric medication must be documented either here, below in the Medication Section, or in the Physician Orders)*:

Discussed in detail w pt. the expectation he participates in treatment. Pt. will be placed in group therapy to assist w skill building. Trial AM trazodone previously offered by MD for anxiety - continue to monitor. It appears at this time pt.'s primary dysfunction is his continued substance abuse.

LIST OF ALL CURRENT PSYCHIATRIC AND MEDICAL MEDICATIONS: *(Include all current medications from transferring unit/facility including medical meds at the first visit after transfer. For subsequent notes, list all psychiatric meds and any changes to medical meds made since admission to this unit). Include dose and frequency for each psychiatric medication listed.*

Psychiatric Medications:

1. Prazosin 2mg PO QAM (anxiety)
2. Trazodone 50mg PO QPM
3.
4.

Medical Medications:

1. none
2.
3.
4.

MEDICATION EDUCATION PROVIDED *(check when provided)*: ☒ as well as risk of co-occurring substance use, pt. verbalized understanding & denies current substance use.

ADDITIONAL INFORMATION:

FOLLOW-UP *(Indicate next appointment)*: 45 days or as otherwise clinically indicated

SIGNATURE/TITLE: [signature] NP **DATE:** 10/16/18

OMH-PHI

Form # MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name: **KING, JOSEPH** C#: **557598**

Date of Birth: [redacted] DIN#: **13A3662**

Unit/ Ward: **820/MSCF**

Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Enter date and time of service and program. Document narrative response to each section.

Date & Time	Program	
5/14/18 10:15 AM	GP	**FOCUS OF SESSION:** (*Include chief complaint, current issues, content of the session)* Pt was seen by this writer for his monthly callout in conjunction with the VTC doctor and to follow up on how he was coping with the loss of his mother. He arrived early, and was observed sitting calmly in waiting room with several peers when this writer approaches the reception area. Mr. King described his moods as "*depressed and anxious.*" He continues to endorse being compliant with medication. "*I need something to calm me down. I'm not hungry, I'm not eating much, and I'm not sleeping.*" Writer pointed out that he recently experienced a significant loss, and that he may experience some physical symptoms as he is working to cope with this. "*I was feeling like this before my mother died. People tell me not to tell you because I will make it worse for myself.*" Writer pointed out that he would be expected to address these reported symptoms in this setting, and that it wouldn't necessarily mean he would be placed in OBS unless he was threatening to harm himself, or experiencing psychiatric decomp. Pt denied experiencing any psychotic symptoms or wanting to harm himself. Mr. King shared with writer that he was in MICA ASAT, and is working on the Lawns and Grounds program. Writer pointed out that it would keep him more active, and that he has already completed the regular ASAT so he knows the foundation. "*I know. This sucks that I have to go back to ASAT.*" Writer pointed out that this is a repercussion for his prior substance use. "*I'm just tired of being in jail.*" Writer asked how he was coping with his mother's passing. Writer offered therapeutic worksheets on grief/bereavement, but pt refused. Mr. King continues to maintain contact with his wife, children, and his sister. No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of an emergency.
	Goal/ Objective #s	**PROGRESS TOWARD TREATMENT PLAN GOAL(S)/OBJECTIVE(S)** (*Note progress or lack of progress toward goals/objectives addressed during session):* A. Patient attended and participated in session. No overt symptoms of depression or anxiety was observed during session although he reported both. His mother recently passed away. He denies any suicidal ideations, plan or intent. B. Copes by reading, doing crossword puzzles, and programming in MICA ASAT and Lawns and grounds. C. Pt is compliant with medication, but was focused on "more medication for my nerves." **MEDICATION COMPLIANCE- Is the patient taking their medication? _X_ Yes ____No** **MENTAL STATUS/CLINICAL OBSERVATION:** Appearance: Pt presented with adequate grooming and hygiene. He was neatly dressed in state issued clothing that was appropriate for the weather. No psychomotor agitation/retardation was observed during session. Adequate attention and concentration exhibited. Pt maintained eye contact. Speech: Speech was at a normal rate, rhythm and tone. There was no increase in volume. No pressured speech or flight of ideas. Thought Process: Clear, logical, organized and goal directed. Mood: Mood ""*depressed and anxious.*"

Form# MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name (Last, First, M.I.) KING, JOSEPH	DIN# 13A3662	C# 243229
	(Continuation)	

5/14/18 10:15 AM		Affect: Affect appeared constricted. Insight/Judgment: Insight and judgment appear functional for this environment. Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional content expressed. Other observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. Pt reported "no sleep" and that he "has no appetite. I'm not hungry." However, he didn't appear tired or underweight. **SUICIDE RISK ASSESSMENT:** **A). Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA?** **____Yes __X__ No If yes, describe briefly and update the CSRA:** No new risk/protective factors. **B). Describe suicide warning signs/triggers which are present or indicate none present *(IS PATH WARM warning signs; prison-based or individual triggers)*:** There is no evidence of any warning signs of acute suicide risk in patient's behavior or affect. Pt reported anxiety, mood change. His mother passed away, but he reported experiencing issues before. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts. **If present, describe the effect on patient's functioning & plan to address: N/A** He does not present with evidence of or symptoms suggestive of suicidal ideation at this time. **FOLLOW-UP/ PLAN:** Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled. **SIGNATURE/TITLE:** Jami Palladino J. Palladino LCSW, SWII

Form # MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name: **KING, JOSEPH** C#: **557598**

Date of Birth: [redacted] DIN#: **13A3662**

Unit/ Ward: **820/MSCF**

Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Enter date and time of service and program. Document narrative response to each section.

Date & Time	Program	
6/25/18 9:30 AM	GP	**FOCUS OF SESSION:** (*Include chief complaint, current issues, content of the session)* Pt was seen by this writer for his monthly callout in conjunction with the VTC doctor and to follow up on how he was coping with the loss of his mother. He arrived early, and was observed standing in the waiting room with several peers when this writer approaches the reception area. Mr. King described his moods as "*still depressed.*" He endorsed being compliant with medication. However, he continues to report that they are ineffective in addressing his symptoms. *I'm still depressed, man. I don't feel like doing anything. I have no motivation to do anything."* Pt adamantly denied experiencing thoughts of self-harm or psychotic symptoms. It can be noted that pt was recently in the hospital, and unresponsive. When asked about how he has been doing, he replied "I was low on sodium and dehydrated." Upon further discussion, pt acknowledged that he has been using suboxone, and has obtained disciplinary tickets for drug use. "I *haven't used in a really long time; like two weeks.*" When asked about how he has been coping with his reported anxiety, pt stated that "*what is that? I don't understand what you're asking. I don't feel anxious at all.*" Pt continues to endorse maintaining contact with his wife, children, and siblings. Writer engaged pt in a discussion about how he has been coping with the passing of his mother. Writer asked if this was a trigger for thoughts of suicide or harming himself. "No way, I'll never do that again." It was decided by the prescriber to taper pt off medication to see how he functions without it, and to start over to figure out what may be helpful. Pt will be seen in one month by prescriber to follow up on how he was doing, and whether medication is clinically indicated. Writer pointed out that concern from MH in relation to using drugs and taking psychotropic medication and what can happen along with the medication not actually addressing what it needs to address because of the substance use. No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of an emergency.
	Goal/ Objective #s	**PROGRESS TOWARD TREATMENT PLAN GOAL(S)/OBJECTIVE(S)** (*Note progress or lack of progress toward goals/objectives addressed during session):* A. Patient attended and participated in session. No overt symptoms of depression or anxiety was observed during session although he reported "depression." Pt recently obtained tickets for drug use, and he acknowledged using suboxone. He denies any suicidal ideations, plan or intent. B. Copes by reading, doing crossword puzzles, and programming in MICA ASAT and Lawns and grounds. C. Pt is compliant with medication, but continues to report that they are ineffective in addressing his reported symptoms.. **MEDICATION COMPLIANCE- Is the patient taking their medication? _X_ Yes ____No** **MENTAL STATUS/CLINICAL OBSERVATION:** Appearance: Pt presented with adequate grooming and hygiene. He was neatly dressed in state issued clothing that was appropriate for the weather. Some psychomotor agitation was observed during session. Pt would continually move his legs up and down. Adequate attention and concentration exhibited. Pt maintained eye contact. Speech: Speech was at a normal rate, rhythm and tone. There was no increase in volume. No

Form# MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name (Last, First, M.I.) KING, JOSEPH	DIN# 13A3662	C# 243229
	(Continuation)	

6/25/18 9:30 AM		pressured speech or flight of ideas. Thought Process: Clear, logical, organized and goal directed. Mood: Mood "*still depressed.*" Affect: Affect appeared constricted. Insight/Judgment: Insight and judgment appear functional for this environment. Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional content expressed. Other observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. Pt reported issues with sleep and motivation. No issues reported in relation to his appetite. He didn't appear tired or underweight. **SUICIDE RISK ASSESSMENT:** **A). Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA?** **____Yes __X__ No If yes, describe briefly and update the CSRA:** No new risk/protective factors. **B). Describe suicide warning signs/triggers which are present or indicate none present *(IS PATH WARM warning signs; prison-based or individual triggers)*:** There is no evidence of any warning signs of acute suicide risk in patient's behavior or affect. Pt reported anxiety, mood change. His mother passed away, but he reported experiencing issues before. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts. **If present, describe the effect on patient's functioning & plan to address: N/A** He does not present with evidence of or symptoms suggestive of suicidal ideation at this time. **FOLLOW-UP/ PLAN:** Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled. **SIGNATURE/TITLE:** Jami Palladino J. Palladino LCSW, SWII

Form # MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name: **KING, JOSEPH** C#: **557598**

Date of Birth: [redacted] DIN#: **13A3662**

Unit/ Ward: **820/MSCF**

Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Enter date and time of service and program. Document narrative response to each section.

Date & Time	Program	
7/23/18 10:30 AM	GP	**FOCUS OF SESSION:** *(Include chief complaint, current issues, content of the session)* Pt was seen by this writer for his monthly callout in conjunction with the VTC doctor and to follow up on the letter he wrote. He arrived early, and was observed standing in the waiting room with several peers when this writer approaches the reception area. Mr. King described his moods as "*I feel terrible. I have a lot of anxiety.*" He is not currently prescribed any medication due to concerns of the prescriber from previous session. He stated that he has been experiencing "*panic attacks, pacing, a lot of anxiety. My heart is racing, I can't breathe, I get hot, I can't sit down and I can't sleep. I have to keep on moving.*" Pt denied experiencing any psychotic symptoms or wanting to harm himself. "*I need help or something. I'm not sleeping good.*" Sleep hygiene was discussed. He was encouraged to refrain from sleeping during the day, and monitoring his caffeine intake. Writer reminded him that medication isn't prescribed for sleep, and noted that he has been continually encouraged to participate in therapy to learn new coping skills. Mr. King endorsed coping with his incarceration by going to the yard, working as a porter, and pacing. He continues to endorse maintaining contact with his wife, children, and his siblings who are supportive of him. When he was informed that he would be prescribed Zoloft, and that it could take a few weeks to get the full effect, pt stated "*aw man, are you kidding me?*" It was also noted that pt had been using substances in addition to taking medication and that he may be experiencing withdrawal as well. No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of an emergency.
	Goal/ Objective #s	**PROGRESS TOWARD TREATMENT PLAN GOAL(S)/OBJECTIVE(S)** *(Note progress or lack of progress toward goals/objectives addressed during session):* A. Patient attended and participated in session. Pt reported that he was coping with "bad anxiety." He was observed pacing in the waiting area. Some psychomotor agitation was noted. He denies any suicidal ideations, plan or intent. B. Copes by going to the yard, working as a porter, and pacing. He denied any C. Pt is not currently prescribed any medication, but is requesting to restart new medication.

MEDICATION COMPLIANCE- Is the patient taking their medication? _X_ Yes ____No

MENTAL STATUS/CLINICAL OBSERVATION:

Appearance: Pt presented with good grooming and hygiene. He was neatly dressed in state issued clothing that was appropriate for the weather. Some psychomotor agitation was observed during session. Pt could not stop moving his legs. Adequate attention and concentration exhibited. Pt maintained eye contact.

Speech: Speech was at a normal rate, rhythm and tone. There was no increase in volume. No pressured speech or flight of ideas.

Thought Process: Clear, logical, organized and goal directed.

Mood: Mood "*I feel terrible. I have a lot of anxiety.*"

Affect: Affect appeared constricted

Insight/Judgment: Insight and judgment appear functional for this environment.

Form# MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name (Last, First, M.I.) KING, JOSEPH	DIN# 13A3662	C# 243229
	(Continuation)	

7/23/18 10:30 AM		Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional content expressed. Other observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. Pt reported "poor sleep" and that he "has no appetite. I'm not hungry." However, he didn't appear tired or underweight. **SUICIDE RISK ASSESSMENT:** **A). Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA?** **____Yes __X__ No If yes, describe briefly and update the CSRA:** No new risk/protective factors. **B). Describe suicide warning signs/triggers which are present or indicate none present *(IS PATH WARM warning signs; prison-based or individual triggers)*:** There is no evidence of any warning signs of acute suicide risk in patient's behavior or affect. Pt reported anxiety, mood change. His mother passed away, but he reported experiencing issues before. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts. **If present, describe the effect on patient's functioning & plan to address: N/A** He does not present with evidence of or symptoms suggestive of suicidal ideation at this time. **FOLLOW-UP/ PLAN:** Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled. **SIGNATURE/TITLE:** Jami Palladino J. Palladino LCSW, SWII

Form # MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name: **KING, JOSEPH** C#: **557598**

Date of Birth: [redacted] DIN#: **13A3662**

Unit/ Ward: **820/MSCF**

Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Enter date and time of service and program. Document narrative response to each section.

Date & Time	Program
8/27/18 9:15 AM	GP

FOCUS OF SESSION: (*Include chief complaint, current issues, content of the session)*

Pt was seen by this writer for monthly callout in conjunction with the VTC doctor. He arrived early, and was observed standing in the waiting room with several peers when writer approaches the reception area. Mr. King described his moods as "*edgy, nervous.*" He acknowledged being compliant with medication, but stated that it was not effectively addressing his symptoms long term. Pt was informed that he would not be prescribed any new medication if he wasn't actively trying to increase coping skills other than medication. He denied experiencing any psychotic symptoms or wanting to harm himself. Pt is continuing to report experiencing no energy, or motivation. He stated "*I lay in bed all day, and I can't sleep. I only get like three or four hours of sleep a night. I'm tired of doing the same thing every day. I can't take this anymore.*" Writer asked pt about his last use of suboxone. "*A long time, like three weeks ago.*" Writer pointed out that he has no idea if the symptoms he is experiencing are a result of his active use of drugs, interaction with medication, or the result of prior use, and he is withdrawing. Writer reminded him that he is responsible for his decisions, and for the repercussions of using substances. He was reminded that he can obtain SHU time for choosing to use substances. "*I'll tell you right now, if I go to the box, I will be suicidal.*" However, he denied wanting to harm himself. "I can't deal with the box." Writer pointed out that he is choosing to engage in activities that have repercussions for them. Writer asked why he had difficulty with the box since he would be by himself. "*I don't like being by myself.*" Writer pointed out that maybe because the actual issue lays within himself, not prison. It was noted that his medication may be discontinued if he is going to actively use substances because they can't effectively treat him if he is using substances on top of that. "*that's not fair. Other people use drugs and get to have their MH medication; why can't I?*" Writer noted that everyone's circumstances are different, and that doesn't necessarily be true. Also, it can be noted that what doesn't affect one person may affect someone totally different. Writer asked if his wife was aware of his substance use. He stated that she was, and that she wasn't happy with him. "*it started because my visits were starting to go bad.*" No further explanation was provided. He was encouraged to actively seek treatment like AA/NA meetings, Pt told staff that he was removed from ASAT for substance use. Writer noted that MH can't help him if he isn't willing to help himself, and that pt doesn't appear motivated for change. She informed staff and pt that in the last year he has eliminated several coping skills in place of using substances. He quit his paint crew job, stopped attending AA/NA, stopped going to religious services, and reports "nothing helps" but isn't willing to complete worksheets, attend coping skills group, or actively participate in treatment. Pt was encouraged to do something like go outside to the yard for exercise, attend AA/NA, do worksheets otherwise medication will be discontinued in the future if he isn't participating in his MH treatment. Mr. King requested an increase of Trazadone for sleep. It was reiterated that medication would not be changed until he attempted to use alternative coping skills. Writer reiterated that medication wasn't prescribed for sleep. No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of an emergency.

Goal/ Objective #s

PROGRESS TOWARD TREATMENT PLAN GOAL(S)/OBJECTIVE(S) (*Note progress or lack of progress toward goals/objectives addressed during session):*

A. Patient attended and participated in session. Pt continues to report "*edgy, anxiety, depression.*" It can be noted that pt is actively using substances. He denies any suicidal ideations, plan or intent.
B. Copes by lying in bed all day.
C. Pt is compliant with medication, but reporting they are ineffective.

Form# MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name (Last, First, M.I.) KING, JOSEPH	DIN# 13A3662	C# 243229
	(Continuation)	

8/27/18 9:15 AM

MEDICATION COMPLIANCE- Is the patient taking their medication? _X_ Yes ____No

MENTAL STATUS/CLINICAL OBSERVATION:

Appearance: Pt presented with good grooming and hygiene. He was neatly dressed in state issued clothing that was appropriate for the weather. Some psychomotor agitation was observed during session. Pt could not stop moving his legs. Adequate attention and concentration exhibited. Pt maintained eye contact.

Speech: Speech was at a normal rate, rhythm and tone. There was no increase in volume. No pressured speech or flight of ideas.

Thought Process: Clear, logical, organized and goal directed.

Mood: Mood "*I'm edgy, anxious, depressed.*"

Affect: Affect appeared constricted and irritable

Insight/Judgment: Insight and judgment appear functional for this environment.

Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional content expressed.

Other observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. Pt reported "poor sleep" but improved appetite." However, he didn't appear tired or underweight.

SUICIDE RISK ASSESSMENT:

A). Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA?

__X__Yes ___ No If yes, describe briefly and update the CSRA: Updated as per policy.

B). Describe suicide warning signs/triggers which are present or indicate none present *(IS PATH WARM warning signs; prison-based or individual triggers)*: Pt reported anxiety, mood change, and admitted to substance use. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts.

If present, describe the effect on patient's functioning & plan to address: N/A

PT was offered worksheets, but pt continues to request additional medication, and refuse worksheets.

FOLLOW-UP/ PLAN: Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled.

SIGNATURE/TITLE: Jami Palladino
J. Palladino LCSW, SWII

OMH-PHI

Form # MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name: **KING, JOSEPH** C#: **557598**

Date of Birth: [redacted] DIN#: **13A3662**

Unit/ Ward: **820/MSCF**

Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Enter date and time of service and program. Document narrative response to each section.

Date & Time	Program	
9/27/18 2:30 PM	GP	**FOCUS OF SESSION:** (*Include chief complaint, current issues, content of the session)* Pt was seen by this writer for his monthly callout. He arrived early, and was observed sitting patiently in the waiting room when this writer approaches the reception area. Mr. King described his moods as "*I still feel terrible.*" Pt continues to report being compliant with medication, but stated "they don't work." He informed writer that he continues to experience "*crazy anxiety, depression, and is not motivated to do anything.*" "I don't know what to do. What medications can I get? I was told by some people that the Prozac is good. I sure wish she would have put me on it so I can feel better." Writer asked about skills he has been using to cope with his reported symptoms. Mr. King denied reviewing any worksheets, using relaxation techniques or attending AA/NA meetings to help him address his substance abuse issues. Writer reminded him that the prescriber was unwilling to make any medication changes if he wasn't complying with treatment recommendations. Mr. King identified playing solitary, and doing crosswords as his main source of coping skills. "*I was kicked out of ASAT, because of that stupid ticket for a dirty.*" Mr. King expressed concern about his upcoming parole board, and his disciplinary record in the last year. Writer pointed out that he is aware that there are consequences for good and bad choices one may make. "*I don't know what I'm going to do if I have to stay incarcerated for another two years. I'm so bored. This isn't fair. I got too much time. I want to go home.*" Writer will make treatment team aware of concerns prior to his parole board 1/2019. Mr. King endorsed maintaining contact with his wife, children, sisters and his brothers who are supportive of him. He noted that his son dropped out of college and is trying to find work. "He plays a mean guitar. He has a band." Writer informed pt that he was just seen by a prescriber, but due to staff changes that he would be meeting with a different prescriber at next visit. He was encouraged to drop a slip explaining his concerns about his medications. Writer reiterated concern from MH in relation to using drugs and taking psychotropic medication and what can happen along with the medication not actually addressing what it needs to address because of the substance use. "I haven't used No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of an emergency.
	Goal/ Objective #s	**PROGRESS TOWARD TREATMENT PLAN GOAL(S)/OBJECTIVE(S)** (*Note progress or lack of progress toward goals/objectives addressed during session):* A. Patient attended and participated in session. He continues to report "extreme anxiety and depression, lack of motivation." No overt symptoms of depression or anxiety was observed during session. Pt recently obtained tickets for unauthorized phone use. No DOCCS referrals received, contact with staff, RCTP/SHU placement has occurred. He denies any suicidal ideations, plan or intent. B. Copes by playing solitaire and doing crossword puzzles. C. Pt is compliant with medication, but continues to report that they are ineffective in addressing his reported symptoms. **MEDICATION COMPLIANCE- Is the patient taking their medication? _X_ Yes ____No** **MENTAL STATUS/CLINICAL OBSERVATION:** Appearance: Pt presented with adequate grooming and hygiene. He was dressed in weather appropriate state issued clothing. Some psychomotor agitation was observed during session. Pt would continually move his legs up and down. Adequate attention and concentration exhibited. Pt maintained eye contact.

Form# MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE **Page 2 of 2**

Patient's Name (Last, First, M.I.) KING, JOSEPH	DIN# 13A3662	C# 243229
	(Continuation)	

9/27/18 2:30 PM		Speech: Speech was at a normal rate, rhythm and tone. There was no increase in volume. No pressured speech or flight of ideas. Thought Process: Clear, logical, organized and goal directed. Mood: Mood "*I still feel terrible.*" Affect: Affect appeared constricted. Insight/Judgment: Insight and judgment appear functional for this environment. Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional content expressed. Other observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. Pt continues to report issues with sleep and motivation. No issues reported in relation to his appetite. He didn't appear tired or underweight. Pt appeared jittery. **SUICIDE RISK ASSESSMENT:** **A). Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA?** **____Yes __X__ No If yes, describe briefly and update the CSRA:** No new risk/protective factors. **B). Describe suicide warning signs/triggers which are present or indicate none present *(IS PATH WARM warning signs; prison-based or individual triggers)*:** There is no evidence of any warning signs of acute suicide risk in patient's behavior or affect. Pt reported anxiety, mood change. His mother passed away, but he reported experiencing issues before. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts. **If present, describe the effect on patient's functioning & plan to address: N/A** He does not present with evidence of or symptoms suggestive of suicidal ideation at this time. **FOLLOW-UP/ PLAN:** Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled. **SIGNATURE/TITLE:** Jami Palladino J. Palladino LCSW, SWII

JP

just Today

State of New York Office of Mental Health (OMH)
Central New York Psychiatric Center
Corrections Based Operations

REFUSAL OF MEDICATION AND/OR TREATMENT

MIDSTATE CORRECTIONAL MHU

Correctional Facility

Joseph King	13A3662	10/27/18
Inmate-patient Name	DIN Number	Date

1. Having been educated about my medication regiment and fully informed of the reasonably foreseeable consequences involved in refusal of the treatment and/or examination in the manner and time prescribed for me, I nevertheless refuse to accept such treatment and/or examination.

2. I agree to notify the OMH staff of any changes in my decision and of any complaints and/or symptoms that I experience.

(Describe the treatment (medication) and/or examination and the consequences discussed with the inmate-patient.
Patient has been informed/educated as to how the refusal of the medication may have a negative Impact with his mental well-being. Medication teaching done to no avail.

Inmate-patient statement or reason for refusal:
Mike may feel different

I REFUSE treatment (medication) and/or examination at this time:

Joseph KING — Inmate Patient Name Print
Joseph King — Inmate Patient Signature

Witnessed by: _____
Signature

_____ OMH Nurse, UC or Designee's Signature
_____ OMH Staff Title

Was an interpreter utilized in the informed consent process? Yes _____ No _____

Form (#) (2/16)

300

JP

State of New York Office of Mental Health (OMH)
Central New York Psychiatric Center
Corrections Based Operations

REFUSAL OF MEDICATION AND/OR TREATMENT

MIDSTATE CORRECTIONAL MHU

Correctional Facility

Joseph King	13A3662	10/31/18
Inmate-patient Name	DIN Number	Date

1. Having been educated about my medication regiment and fully informed of the reasonably foreseeable consequences involved in refusal of the treatment and/or examination in the manner and time prescribed for me, I nevertheless refuse to accept such treatment and/or examination.

2. I agree to notify the OMH staff of any changes in my decision and of any complaints and/or symptoms that I experience.

(Describe the treatment (medication) and/or examination and the consequences discussed with the inmate-patient.
Patient has been informed/educated as to how the refusal of the medication may have a negative Impact with his mental well-being. Medication teaching done to no avail.

Inmate-patient statement or reason for refusal:

Prozac dont like the way I, do effects

I REFUSE treatment (medication) and/or examination at this time:

Joseph King
Inmate Patient Name Print

Joseph T. King
Inmate Patient Signature

Witnessed by: _____
Signature

_____
OMH Nurse, UC or Designee's Signature

_____
OMH Staff Title

Was an interpreter utilized in the informed consent process? Yes _____ No _____

Form (#) (2/16)

JP

State of New York Office of Mental Health (OMH)
Central New York Psychiatric Center
Corrections Based Operations

REFUSAL OF MEDICATION AND/OR TREATMENT

MIDSTATE CORRECTIONAL MHU

Correctional Facility

Joseph King	13A3662	11/5/18
Inmate-patient Name	DIN Number	Date

1. Having been educated about my medication regiment and fully informed of the reasonably foreseeable consequences involved in refusal of the treatment and/or examination in the manner and time prescribed for me, I nevertheless refuse to accept such treatment and/or examination.

2. I agree to notify the OMH staff of any changes in my decision and of any complaints and/or symptoms that I experience.

(Describe the treatment (medication) and/or examination and the consequences discussed with the inmate-patient.
Patient has been informed/educated as to how the refusal of the medication may have a negative Impact with his mental well-being. Medication teaching done to no avail.

Inmate-patient statement or reason for refusal:
PROZAC I don't like the way I feel or side effects

I REFUSE treatment (medication) and/or examination at this time:

Joseph KING	Joseph King
Inmate Patient Name Print	Inmate Patient Signature

Witnessed by: _____
Signature

_____ _____
OMH Nurse, UC or Designee's Signature OMH Staff Title

Was an interpreter utilized in the informed consent process? Yes _____ No _____

Form (#) (2/16)

302

Form # MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name: **KING, JOSEPH** C#: **557598**

Date of Birth: [redacted] DIN#: **13A3662**

Unit/ Ward: **820/MSCF**

Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Enter date and time of service and program. Document narrative response to each section.

Date & Time	Program
11/2/18 10 AM	GP

FOCUS OF SESSION: (*Include chief complaint, current issues, content of the session)*

Pt was seen by this writer for his monthly callout. He arrived on time and was observed sitting calmly in waiting room with several peers when this writer approaches the reception area. Mr. King described his moods as "*I feel edgy; and worried.*" He has been refusing medication, stating that Paxil "*makes me feel weird.* " Pt informed writer that he was told by OMH nursing that his night medication both may be discontinued if he continues to refuse them. "I find myself waiting around all day until I can get that Trazadone. They can't do that. I need it. that is the only time I feel relatively alright." Pt continues to deny experiencing any psychotic symptoms or wanting to harm himself. "*I'll never do THAT again.*" Mr. King shared with writer that he has been going to church, attending AA meetings, and going to the yard. He noted that he continues to maintain contact with his wife, his children, and his sister who are supportive of him. Pt continues to express frustration with his inability to deal with his reported "*edginess, nerve problem.*" He noted that he has been working as a porter, and is waiting to return to ASAT. Writer encouraged him to speak to his prescriber about any concerns he has regarding medication. He was reminded of the importance of utilizing appropriate supports to maintain his sobriety and cope with his circumstances. No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of an emergency.

Goal/ Objective #s

PROGRESS TOWARD TREATMENT PLAN GOAL(S)/OBJECTIVE(S) (*Note progress or lack of progress toward goals/objectives addressed during session):*

A. Patient attended and participated in session. No overt symptoms of depression or anxiety was observed although pt reported both. Pt does not appear anxious or depressed. He denies any suicidal ideations, plan or intent.
B. Copes by going to church, AA meetings, and to the yard.
C. Pt has been refusing medication.

MEDICATION COMPLIANCE- Is the patient taking their medication? __ Yes __X_No

MENTAL STATUS/CLINICAL OBSERVATION:

Appearance: Pt presented with adequate grooming and hygiene. He was dressed in weather appropriate state issued clothing. No psychomotor agitation or retardation was noted. Adequate attention and concentration exhibited. Pt maintained eye contact.

Speech: Speech was at a normal rate, rhythm and tone. There was no increase in volume. No pressured speech or flight of ideas.

Thought Process: Clear, logical, organized and goal directed.

Mood: Mood "*edgy; worried.*"

Affect: Affect appeared constricted but incongruent with reported moods.

Insight/Judgment: Insight and judgment appear functional for this environment.

Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional content expressed.

Form# MED CNY 349 (7/12)

PRIMARY THERAPIST PROGRESS NOTE

Patient's Name (Last, First, M.I.) KING, JOSEPH	DIN# 13A3662	C# 243229
	(Continuation)	

11/2/18 10 AM		Other observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. No issues reported in relation to his appetite or sleep and didn't appear tired or underweight. **SUICIDE RISK ASSESSMENT:** **A). Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA?** ____Yes __X__ No **If yes, describe briefly and update the CSRA:** No new risk/protective factors. **B). Describe suicide warning signs/triggers which are present or indicate none present *(IS PATH WARM warning signs; prison-based or individual triggers)*:** There is no evidence of any warning signs of acute suicide risk in patient's behavior or affect. There were no signs of anger, anxiety, withdrawal, mood change, purposelessness, hopelessness, recklessness or feelings of being trapped. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts. **If present, describe the effect on patient's functioning & plan to address: N/A** He does not present with evidence of or symptoms suggestive of suicidal ideation at this time. **FOLLOW-UP/ PLAN:** Primary therapist will continue to meet with patient monthly, or as needed Prescriber will continue to meet with patient every 3 months, or as scheduled. **SIGNATURE/TITLE:** Joni Palladino J. Palladino LCSW, SWII

PHYSICIAN'S ORDERS

Allergies _____

Specific Considerations _____

☒ None Known

Patient's Name (Last, First, M.I.) King, Joseph

C# 243224 DIN# 13A3662 DOB [redacted]

Facility CNMC Unit Midstate CF

PrincipalDiagnosis: Adjustment Disorder - Mixed Anxiety + Depressed Mood

Physician to indicate Drug Name, Dosage, Frequency, Form, and Route

Date Order Written 8/27/18

Name King, Joseph DIN# 13A3662

Start Date 8/27/18 Stop Date 11/25/18

Zoloft 50mg tab PO qPM

Trazodone 50mg tab PO qPM

Physician Signature: [signature] MD R.N. Signature: _____

Physician to indicate Drug Name, Dosage, Frequency, Form, and Route

Date Order Written 10/16/18

Name King, Joseph DIN# 13A3662

Start Date 10/16/18 Stop Date 11/4/19

Discontinue: Zoloft 50mg tab PO QPM

Labs: Chem 1 10/16/18 2145

Start: Prozac 20mg cap PO Q AM

Continue: Trazodone 50mg tab PO QPM

Noted 10/16/18

Physician Signature: [signature] NP R.N. Signature: [signature] RN 1708

Physician to indicate Drug Name, Dosage, Frequency, Form, and Route

Date Order Written 11/6/18

Name King, Joseph DIN# 13A3662

Start Date _____ Stop Date 11/6/18

DCS 11/6/18 1720

Discontinue:

Prozac 20mg cap PO QAM

Trazodone 50mg tab PO QPM

11/6/18C 1450

Physician Signature: [signature] NP R.N. Signature: [signature]

King v. Ward, et al. 9:20-cv-1413 (TJM/ML)

Form 89 MED (F) (6-00)

327